TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Edward Icaza MD

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-17-1746-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
February 7, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $297.11

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Code 99204 was denied per Medicare guidelines and correct coding rules, as documentation does not support this level of service. HCPCS codes A4556, electrodes per pair and A4215, needle sterile any size, were denied as supplies are not separately payable per Medicare guidelines."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2016	99204, A4556, A4215	$297.11	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X263 – The code billed does not meet the level/description of the procedure performed/documented
   - MSCP – In accordance with the CMS physician fee schedule rule for status code 'P', this service is not separately reimbursed when billed with other payable services

- X212 – This procedure is included in another procedure performed on this date
- 193- The code billed does not meet the level/description of the procedure performed/documented
- W3 – The code billed does not meet the level/description

Issues

1. Are the insurance carrier's reason for denial of the evaluation and management code supported?
2. Are supplies separately payable?

Findings

1. The requestor is seeking $297.11 for professional medical services rendered on October 22, 2016.

   The insurance carrier denied Code 99204 as X263 – "The code billed does not meet the level/description of the procedure performed/documented."

   28 Texas Administrative Code §134.203 (b) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

The submitted code in dispute is 99204 – "Office or other outpatient visit for the evaluation and management of a new patient, which **requires these 3 key components**: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family."

Review of the submitted medical documentation with "Electromyography (EMG) Report," date October 22, 2016 finds the following:

Required Element	Present within Submitted Documentation Findings	Requirement of Code Met
Comprehensive History	History of present illness: three conditions = Extended Problem Focused Review of systems: Musculoskeletal = Pertinent to problem Past medical, family, social history, areas: Past Medical History = Pertinent to Problem	No
Comprehensive Examination	Body Areas: Back, three extremities = Expanded problem focused	No
Moderate complexity medical decision making	Number of Diagnoses or Treatment options points = 1 Amount and/or Complexity of Data Reviewed = 1	No Straightforward
Forty-five minutes face to face with the patient/and or family	No documentation found to indicate face to face time	n/a

Based on the above, the carrier's denial X253 –"Payer deems the information submitted does not support the level of service" upheld.

2. The remaining services in dispute are codes A4556 – Electrodes, per pair and A4215 – Needles, only.

   Per the above referenced Rule 134.203 (b) the Medicare payment policy found for each code is as follows;

   - A4556 – Status code 'P' Bundled/Excluded Code.

     The carrier denied as MSCP – "This service is not separately reimbursed when billed with other payable services." Based on the status of this code the carrier's denial supported.

   - A4215 – Status code 'X" Statutory Exclusion.

     The carrier denied as X212 – "This procedure is included in another procedure performed on this date." Based on the status of this code the carrier's denial supported.

   The Division finds no additional payment is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		February 28, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.